Your Basic Health coverage is changing for 2004

Look inside to find changes in:

- Your premiums
- Your copays
- Your prescription copay
- Your benefits and responsibilities

Basic Health™

HCA 25-806 (9/03)

Si desea ayuda en español, llame al 1-800-321-0291.

Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

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A message to Basic Health members

Due to the severe budget crisis facing Washington, Basic Health has to make major changes* to the program to keep as many members covered as possible and still provide you with a high-quality program.

Starting in January 2004, you will have to share more of the costs for your health care coverage. Your coverage for some major benefits and services will remain the same, such as preventive and maternity care services. Other benefits and services may have different or higher costs. However, the benefits that are available to you now will continue in 2004.

Many state health care programs and private health insurance plans are experiencing great losses. Some state programs that have been available in the past are being cancelled or severely limited. Basic Health is no exception. Also due to the state budget crisis, there are enrollment limits in Basic Health. This means that **if you leave Basic Health, you may have to wait to re-enroll until space is available.**

*2004 benefit changes affect Basic Health members, not Basic Health *Plus* or Maternity Benefits Program members.

To help you understand upcoming changes in Basic Health, this publication has information about:

- **Your benefits**;
- **Cost-sharing responsibilities** you will have, including copays, coinsurance, deductibles, and out-of-pocket maximums; and
- **How these costs apply** to health care services you may receive.

Keep this guide as a reference until you receive your Basic Health *Member Handbook* in early 2004. It includes valuable information about your health care coverage.

Also in 2004, monthly premiums will increase for every income band. Look for more information on premium increases and other changes in your *2004 Open Enrollment* booklet, which will be sent in the next few weeks. It will also include information on health plans available to you and how to add family members to your Basic Health account.

What's the same in 2004?

The following benefits will remain the same in 2004 and at no cost to you.

- Maternity services – see maternity care benefits on page 4
- Skilled nursing, hospice, and home health care
- Preventive care – routine well-child and well-adult physicals, including:
  - Mammograms
  - Immunizations
  - All tests from preventive care visits
  - PAP tests

Your open enrollment booklet will include specific monthly premiums and health plans available to you.

Basic Health: Valuable health care coverage

Starting in 2004, you will share more of the costs for your health care coverage. Even with the major changes, your Basic Health (BH) coverage is still available at a reasonable cost compared with private health insurance. It is very important to keep your health care coverage, because as the chart below shows, the cost of not having health care coverage can add up quickly.

EXAMPLE:	Your costs **with** Basic Health	**Without** Basic Health*
Office visit	$15	$75
Prescription medicine *Tier 1 examples:* *Amoxicillin (10-day supply)* *Omeprazole (30-day supply)*	 $10 $10	 $23 $112
Laboratory/radiology services – outpatient (does not include MRIs or CT scans)	$0	$120
Urgent care visit	$15	$75

*Costs for services or treatments may vary.

What's changing in 2004?

Beginning January 1, 2004, each member enrolled in Basic Health will be responsible for a greater share of the cost for his or her health care coverage. Cost sharing comes in the form of copays, coinsurance, and deductibles. In addition, each member will have an out-of-pocket maximum (as explained in this section). In 2004, you will be responsible for paying:

Copay – A set dollar amount you pay when receiving specific services. In most cases, this will be $15, except for prescription drugs, emergency room visits, and laboratory/radiology services. **Copays do not apply to your deductible, coinsurance, or out-of-pocket maximum**.

Deductible – The amount you pay before your health plan starts to pay for covered services. In 2004, you will be responsible for paying the first $150 of certain covered medical costs before your health plan pays the 80% coinsurance. The $150 deductible has to be met every calendar year for each family member enrolled in Basic Health. **Your deductible does not apply towards your out-of-pocket maximum.** You may receive a bill from your health plan and/or provider.

Coinsurance – For certain services, you will be responsible for paying 20% of the cost. Your health plan pays the remaining 80%. You may receive a bill from your health plan and/or provider.

Out-of-pocket maximum – Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you reach your out-of-pocket maximum, you are not responsible for any further coinsurance costs for covered benefits and services received during that year. Your health plan will pay 100% of the coinsurance for all covered benefits and services. The $1,500 out-of-pocket maximum applies to each family member enrolled in Basic Heatlh.

Please note: If you change plans any time during the year except during open enrollment, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

2004 Basic Health benefits and services

Benefits and Services NOT Subject to the Deductible and Coinsurance

The $150 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year do not apply to the following benefits and services.

Benefit/Service	Member's Payment Responsibility	Description
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. No copay for preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*	 Tier 1 – $10 copay Tier 2 – 50% of the drug cost	30-day supply Tier 1 includes generic drugs in health plan's formulary. Tier 2 includes brand-name drugs in health plan's formulary.
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice, and home health care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.

*Different health plans have different formularies (a list of approved prescription drugs). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Benefits and Services Subject to the Deductible and Coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must first pay your $150 annual deductible. Once you meet your $150 deductible, all coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services listed on page 4. If you change health plans any time during the year except during open enrollment, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/Service	Member's Payment Responsibility	Description
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. See other professional services below.
Hospital, outpatient	20% coinsurance; deductible applies	
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient, surgeries, anesthesia, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count towards 12-visit maximum. Outpatient visits are subject to $15 copay (see office visits).
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/physical therapy	20% coinsurance; deductible applies	Up to six visits combined for postoperative treatment following reconstructive joint surgery, as long as visits are within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient. $300 maximum facility charge per admittance.	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see office visits).
Organ transplants	Deductible, coinsurance, and copays apply by specific service.	12-month waiting period, except for newborns or for a condition that is not pre-existing.

Basic Health definitions and examples

Copay

A set dollar amount you pay when receiving specific services or treatments. Copays do not apply to your deductible, coinsurance, or out-of-pocket maximum. Following are copays you will be responsible for in 2004:

Office visit:	$ 15
Prescription drugs	
Tier 1:	$ 10
Tier 2:	50% of the drug cost
Emergency room visit:	$100

How it works:
Sally takes her 11-year-old son, Charlie, to the pediatrician for a bad cough. Sally pays the $15 office visit copay at the doctor's office.

Deductible

The amount you pay before your health plan starts to pay for covered services. In 2004, you will be responsible for paying the first $150 of covered medical costs before your health plan pays the 80% coinsurance. The $150 annual deductible has to be met for each family member enrolled in Basic Health. If you change plans any time during the year except during open enrollment, the amount you've paid toward your deductible for covered family members will start over with your new health plan.

How it works:
John, age 39, falls off his roof and is taken to the hospital by ambulance. The ambulance service is subject to his annual deductible. John has not paid anything toward his deductible, so he is responsible for the first $150 of the $500 cost. He also is responsible for paying 20% coinsurance of the remaining bill.

AMBULANCE SERVICES:	$500
John's deductible:	$150
Remaining bill:	$350
John pays 20% of remaining bill:	$ 70
Health plan pays 80% of remaining bill:	$280
John's total cost:	$220

Because John has met his $150 deductible, he will only pay the 20% coinsurance for the rest of the year.

Please note: 2004 benefit changes affect Basic Health members, not Basic Heatlh *Plus* or Maternity Benefits Program members.

Coinsurance

The percentage you pay when your health plan pays less than 100% for covered services. Coinsurance does not apply until you have paid your annual deductible. In 2004, you will be responsible for paying 20% of the cost for services that have a coinsurance. Your health plan pays the remaining 80%.

How it works:
Sally, age 35, is hospitalized for an injury. The hospital stay costs $1,000. The hospital stay is subject to her annual deductible. If Sally has already paid her annual deductible, she pays 20% coinsurance for the hospital stay and her health plan pays the remaining 80%.

HOSPITAL STAY:	$1,000
Sally pays 20%:	$ 200
Health plan pays 80%:	$ 800

Out-of-pocket maximum

Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you or another covered family member reaches the out-of-pocket maximum, you are not responsible for any further coinsurance costs for covered services received by that person during the year. Your health plan will pay 100% of all coinsurance costs. If you change plans any time during the year except during open enrollment, the amount you've paid toward your out-of-pocket maximum for covered family members will start over with your new health plan.

How it works:
When John fell off the roof, he seriously damaged his knee. He will need three surgeries in 2004 to repair the damage. Each surgery will cost $5,000 and his coinsurance is 20%. The surgeries are subject to his annual deductible, which he has already met with the ambulance service.

FIRST SURGERY:	$5,000
John pays 20%:	$1,000
Health plan pays 80%:	$4,000

For the second surgery, John will not have to pay the full 20% coinsurance because he has already paid $1,000 for the first surgery and his total annual out-of-pocket maximum is $1,500.

SECOND SURGERY:	$5,000	
John pays:	$ 500	(the remainder of his $1,500 out-of-pocket maximum)
Health plan pays:	$4,500	

As long as the third surgery occurs in 2004, John will not have to pay any deductible or coinsurance because he has already paid his portion with the ambulance service and the first two surgeries.

THIRD SURGERY:	$5,000
John pays:	$ 0
Health plan pays:	$5,000

John will still be responsible for paying his copays for follow-up office visits, prescription drugs, and for non-covered services.

Cost sharing

Each member enrolled in Basic Health is responsible for sharing the cost of his or her health care coverage. Cost sharing comes in the form of copays, coinsurance, deductibles, and out-of-pocket maximums.

Explanation of Benefits (EOB)

Each time you receive medical services, you will be sent a detailed statement from your health plan that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you pay.

Meet the Richardsons

Peter, Cathy, and their 11-year-old son, Davie, signed up for Basic Health in November 2003 and will start receiving coverage in January 2004. They have a $150 deductible that has to be met for each family member before their health plan pays the 80% coinsurance on certain benefits. Once they have met their individual deductibles, they are responsible for 20% of the covered service. All coinsurance payments will go toward their annual out-of-pocket maximum, which is $1,500 per person, per year. The following examples* will give you an idea of how the new benefits and coverage with Basic Health will work.

April 3

Peter goes to the emergency room with a broken leg. He has x-rays taken. The doctor puts a cast on his leg and writes a prescription.

Peter pays:
$100 emergency room visit copay
$10 Tier 1 generic prescription copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

April 25

Peter follows up with his primary care provider (PCP) for his broken leg. The doctor removes the cast in his office.

Peter pays:
$15 office visit copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

March 3

Cathy has her annual exam. Since this is a preventive care service, there is no charge.

Cathy pays:
$0 copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

May 20

Cathy has been getting frequent headaches. She goes to see her PCP and receives a referral for six visits to see a specialist.

Cathy pays:
$15 office visit copay for each visit

Deductible Total: $0 **Out-of-Pocket Max.: $0**

January 4

Davie needs a well-child exam. Since this is a preventive care service, there is no charge.

Davie's parents pay:
$0 copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

March 20

Davie falls and hits his head on the driveway. His parents take him to the emergency room.

Davie's parents pay:
$100 emergency room visit copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

*Actual cost for health care services may vary.

June 4
Peter goes to urgent care over the weekend for a sore throat. The doctor writes him a prescription.

Peter pays:
$15 urgent care copay
$10 Tier 1 generic prescription copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

August 27
Peter is referred to a specialist by his PCP.

Peter pays:
$15 office visit copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

June 2
Cathy sees the specialist, who sends her to have a CT scan. The CT scan costs $1,000. The CT scan is subject to the annual deductible and 20% coinsurance. Cathy has to pay the $150 deductible and also 20% of the remaining CT scan cost.

Cathy pays:
$15 office visit
$150 deductible
$170 coinsurance (20% of remaining CT scan cost)

Deductible Total: $150 MET **Out-of-Pocket Max.: $170**

July 17
Cathy sees her specialist for follow-up care.

Cathy pays:
$15 office visit copay

Deductible Total: $150 MET **Out-of-Pocket Max.: $170**

March 23
Davie sees his pediatrician for follow-up care from his fall.

Davie's parents pay:
$15 office visit copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

June 10
Cathy takes Davie to the pediatrician's office. He is diagnosed with an ear infection and the doctor writes him a prescription.

Davie's parents pay:
$15 office visit copay
$10 Tier 1 generic prescription copay

Deductible Total: $0 **Out-of-Pocket Max.: $0**

Frequently asked questions and answers

Can I change my health plan?

Basic Health members can change their health plan during open enrollment if more than one health plan is available. Open enrollment occurs in the fall every year, with changes effective January 1 the following year.

If you change your health plan for any reason other than during open enrollment, your deductible and out-of-pocket maximum start over. These costs will not transfer between health plans.

What happens when I see a specialist?

If your primary care provider (PCP) refers you to a specialist and your health plan has authorized the referral, you will pay a $15 copay for the office visit.

Will I receive bills from my doctor and my health plan?

In most cases you will receive bills from your provider's office. You may also receive bills from facilities if you have had a test such as an MRI or CT scan, or if you were an inpatient at a hospital. Your health plan will send you an Explanation of Benefits (EOB) that will include a detailed statement that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you are responsible for paying. The EOB is **not** a bill from the health plan.

If you have additional questions about bills from your provider, contact your provider's billing office. If you have questions regarding the EOB sent by your health plan, contact your health plan directly.

What if I can't afford to pay the deductible?

If you are unable to pay your bill in full, you should contact your provider's billing office directly to see if they will make a payment arrangement for you. Providers can refuse to treat you if you cannot pay at your visit. However, many providers will try to work with you so you can get the care you need. If you do not pay the portion of your health care costs you are responsible for, you may be disenrolled from Basic Health.

When will I know if I've reached my out-of-pocket maximum for the year?

Your health plan will track the services you receive and payments applied to each service throughout the calendar year. Contact your health plan directly for additional information about how this will be communicated to you.

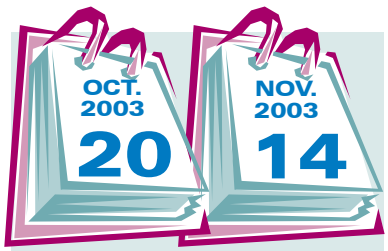
Will I be expected to pay the deductible and coinsurance when I receive services or treatments, or will I be billed for them?

In most cases, you will be required to pay the portion of the bill to meet your deductible at the time you receive the health care service. Once you have met your deductible, you will be billed for the 20% coinsurance you are responsible for after your health plan has paid 80%.

Important dates to remember

Oct. 17

Open enrollment booklet mailed



Oct. 20 - Nov. 14

Open enrollment, when members can make plan changes and add family members

January 1

New benefits and premiums take effect

January/February

- Basic Health Member Handbook mailed
- Maternity Benefits/ Basic Health *Plus* guide mailed

Open enrollment is coming! Please keep this guide for reference.

Questions or comments?
Contact us at www.basichealth.hca.wa.gov or call 1-800-660-9840.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

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